Ramping Up Care Coordination for Medicaid Beneficiaries with Disabilities

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Summary/Abstract

Approximately 5 million Medicaid beneficiaries have gained coverage by virtue of a disability and do not have Medicare coverage. These individuals comprise 10 percent of Medicaid beneficiaries but account for 28 percent of nationwide Medicaid spending. This SSI subgroup's Medicaid per capita costs are six times larger than occur in the TANF and TANF-related Medicaid subgroups.

Due to these SSI beneficiaries' relatively stable Medicaid coverage, high usage of services, high prevalence of chronic conditions (including both acute health and behavioral health comorbidities), this subgroup is a particularly good fit for well-designed coordinated care programs. However, this population has often been entirely or largely excluded from states' Medicaid coordinated care programs.

This paper quantifies, at both the national and the state level, the degree to which coordinated care is used for the TANF population, for the SSI population (with disabled adults and children shown separately), and for Medicaid/Medicare dual eligibles. Nationwide, only 18% of Medicaid spending for the SSI non-Medicare subgroup occurred via capitation payments to integrated care organizations – versus 44% for the TANF and TANF-related subgroups.

The objective of the paper is to demonstrate the size of the opportunity that exists in nearly every state to increase the role of coordinated care for this SSI high-need, high-cost subgroup. States are encouraged to take advantage of the substantial base of knowledge and experience that now exists regarding how to design and operate these initiatives effectively for special needs subgroups.

In the current fiscal climate, Medicaid literally cannot afford to simply pay claims for this costly group via the traditional fee-for-service setting. In addition to large-scale cost savings in most states, important opportunities also exist to improve health outcomes through the outreach, education, and other care coordination components that a well-structured coordinated care program delivers.

I. Introduction

A. Background

Throughout the past two decades, many states have implemented and operated innovative and comprehensive Medicaid coordinated care models. In many regards, these Medicaid initiatives represent the most ambitious use of integrated care seen in our nation's health system. Examples of key program design techniques that have differentiated Medicaid managed care from Medicare Advantage and other public sector coordinated care programs are briefly summarized below:

Mandatory Enrollment of the Beneficiary Population: The mandatory enrollment model was initially pilot-tested in several geographic areas decades ago. These demonstrations proved to be successful and this enrollment model is now the fundamental approach used by states in implementing Medicaid capitation contracting initiatives with managed care organizations (MCOs).[1] Requiring – rather than inviting -- the target population to participate in the state's Medicaid coordinated care program has been a critical feature in removing marketing costs (direct marketing to beneficiaries is typically prohibited), providing economies of scale to the coordinated care programs, and forcing providers to participate constructively in a cost-effective coverage system if they desire to retain or increase their Medicaid revenues.

Competitive Procurements: There are two approaches for contracting with Medicaid MCOs – an application process (as used by Medicare Advantage, whereby all successful applicants may participate) and a competitive procurement process. States have increasingly chosen to select Medicaid MCOs through a competitive procurement process. This approach allows states to select only the highest-qualified health plans and to limit the number of MCOs they are partnering with. This also ensures the "winning" MCOs considerable market share in return for their contractual commitments and competitive price offers.

Performance Incentives: Many states leverage their auto assignment (for persons who do not proactively select an MCO) to award greater enrollment to health plans that achieve desired state objectives (HEDIS scores, favorable price bid, etc.). Many states also use capitation withhold/bonus mechanisms to encourage desired performance outcomes. In addition, an MCO is particularly vulnerable to non-renewal of its contract in a competitive procurement environment if it is deemed a low performer relative to others in the market. In an application

[1] There have been situations, such as the District of Columbia's initiative for special needs children, where the voluntary enrollment model has garnered a high level of beneficiary participation at minimal marketing cost. Typically, however, beneficiary participation has been well below 50% in the voluntary enrollment setting.

situation such as Medicare Advantage, a health plan does need not “excel” or exceed the government’s contract requirements to retain its market presence.

Sophisticated Contractual Requirements: States have become adept at specifying the programmatic features they desire their MCOs to provide in all operational areas. These form the “baseline” contract requirements for participating MCOs, with additional features being added by the MCOs through the competitive bid process. The level of purchasing sophistication on the part of the Medicaid agencies has evolved favorably, with these requirements now often tailored to a wide range of special needs population subgroups. In turn, on the MCO side there is now considerable experience and expertise in operating highly integrated programs for all Medicaid subgroups.

Full Focus On Care Coordination: While enrollee financial incentives and provider price discounts play central roles in many coordinated care programs, these techniques are used only modestly/rarely in the Medicaid coordinated care arena. The impoverished Medicaid population understandably faces no monthly premiums and minimal or no cost sharing regardless as to whether coverage occurs in the fee-for-service (FFS) or MCO setting. On the provider side, Medicaid’s FFS payment rates are typically so low that discount-for-volume price negotiations are not viable or achievable. For these reasons, Medicaid coordinated care programs must rely *entirely* on the care coordination itself (including outreach initiatives to help keep enrollees’ health status stable) to create savings.

B. Further Opportunities For Integrated Care in Medicaid

Notwithstanding this evolution and the many successful achievements that have occurred in the Medicaid coordinated care arena, substantial opportunity exists for considerably greater use of these approaches. While Medicaid capitation contracting now occurs in 40 states, less than one-fourth of the nation’s Medicaid spending occurs through capitation payments to integrated care organizations. Data tabulated for 2008 across all state Medicaid programs (and the District of Columbia) are shown in Exhibit 1, with the bottom row demonstrating that 23% of Medicaid spending occurred in the form of capitation payments.

Exhibit 1. Capitation Contracting In Medicaid by Major Eligibility Category

2008 Medicaid Statistics							
Medicaid Population Group	Average Number of Beneficiaries	Percentage of Medicaid Beneficiaries	Medicaid Expenditures	Percentage of Medicaid Expenditures	% Of Expenditures Paid Via Capitation	Average Annual Medicaid Cost Per Beneficiary
Disabled Non-Medicare	5,040,464	10%	$83,932,978,385	28%	18.2%	$16,652
Medicaid/Medicare Dual Eligibles	8,192,927	17%	$114,825,638,008	39%	8.5%	$14,015
TANF, TANF-Related, & Other	35,000,507	73%	$98,070,996,095	33%	43.9%	$2,802
Total, All Beneficiaries	**48,233,898**	**100%**	**$296,829,612,488**	**100%**	**23.0%**	**$6,154**

Source: Special Needs Consulting Services tabulations using CMS MSIS data files

Exhibit 1 also presents information for three major Medicaid beneficiary subgroups: 1) disabled beneficiaries who do not have Medicare coverage; 2) persons dually eligible for Medicare; and 3) all other Medicaid beneficiaries (primarily the TANF population). This latter group of predominantly TANF beneficiaries represents nearly three-fourths of all Medicaid beneficiaries but only one-third of expenditures. The TANF population is the healthiest Medicaid subgroup (with less than one-fifth the per capita costs of the other two groups); this subgroup has the most volatile and shortest-lasting Medicaid eligibility. All these dynamics diminish the effectiveness that coordinated care approaches can achieve with TANF beneficiaries. Somewhat ironically, however, this is the Medicaid subgroup integrated care initiatives have most prominently served. During 2008, 44% of nationwide expenditures in the TANF and TANF-related cohort were paid by capitation.

Medicaid/Medicare dual eligibles are where the least amount of capitation contracting occurs – representing less than 10% of Medicaid spending during 2008. While the dual eligibles are highly amenable to coordinated care impacts in terms of their high per capita costs (particularly when the "Medicare side" is taken into account) and coverage continuity, the funding complexities between Medicare and Medicaid significantly weaken states' ability to achieve cost savings. In the current fiscal climate, it is not surprising to see only a modest degree of state-sponsored coordinated care activity with dual eligibles. CMS is working to improve the cost-savings opportunities for states that introduce and expand integrated care programs for dual eligibles. Thus, it is likely that new coordinated care programs will emerge for dual eligibles and it is possible that significant growth will occur.

A forthcoming Special Needs Consulting Services paper will explore the opportunities that exist with dual eligibles, and discuss the importance of taking advantage of the "lessons learned" from the evolution of both Medicaid managed care and the Medicare Advantage program to maximize the considerable success integrated care can achieve in this population sector. The remainder of this paper, however, focuses on the top row in Exhibit 1 – disabled Medicaid beneficiaries who do not have Medicare coverage.

This disabled subgroup includes approximately five million persons whose average Medicaid per capita costs are roughly six times those of the TANF and TANF-related subgroup. The disabled population has an extremely high prevalence of chronic conditions including co-morbidities across physical and behavioral health. This subgroup has high per capita costs for inpatient care and pharmacy services and also has stable Medicaid eligibility. (The most common eligibility change in this category involves persons also acquiring Medicare coverage and becoming dual eligibles.) All these characteristics are indicative of the need for and value of integrated care interventions. However, less than one-fifth of nationwide Medicaid spending in this beneficiary cohort was paid to integrated care organizations.

The level of Medicaid expenditures during 2008 in each state for the non-dual disabled subgroup is presented in Exhibit 2. This Exhibit also presents the percentage of total Medicaid spending that the non-dual disabled subgroup represents in each state. Nationwide, this subgroup accounted for $84 billion in Medicaid expenditures, representing 28% of total Medicaid spending. In most states (35), the disabled non-duals accounted for between 24% and 32% of Medicaid expenditures.

Appendix A presents more detailed information for 2008, showing each state's expenditures broken out between disabled children and disabled adults, the average number of covered persons, per member per month costs, and the proportion of costs paid via capitation.

The remainder of the paper quantifies, on a state-by-state basis, the magnitude of the opportunity that exists to broaden the role of Medicaid coordinated care in the disabled non-Medicare beneficiary category.

Exhibit 2. State Medicaid Expenditures on Disabled Beneficiaries who are not Dually Eligible for Medicare, 2008

STATE	Total Costs, All Disabled Non-Duals	Total Costs, All Medicaid Beneficiaries	Disabled Non-Duals as % of Total Medicaid Expenditures
Alaska	$258,046,957	$974,014,084	26%
Alabama	$914,100,781	$3,507,716,560	26%
Arkansas	$941,582,481	$3,251,172,381	29%
Arizona	$1,516,554,548	$6,583,579,070	23%
California	$9,844,359,614	$32,245,479,726	31%
Colorado	$828,800,512	$2,984,631,555	28%
Connecticut	$746,006,910	$4,143,762,719	18%
District of Columbia	$583,947,303	$1,739,249,831	34%
Delaware	$271,451,712	$1,137,201,381	24%
Florida	$3,553,591,756	$13,223,929,421	27%
Georgia	$1,874,241,400	$6,863,188,421	27%
Hawaii	$239,816,114	$1,014,143,923	24%
Iowa	$726,499,239	$2,691,421,624	27%
Idaho	$454,324,539	$1,262,942,856	36%
Illinois	$2,814,310,443	$10,235,178,181	27%
Indiana	$1,318,810,536	$4,941,164,675	27%
Kansas	$643,690,510	$2,295,600,614	28%
Kentucky	$1,530,802,116	$4,474,558,097	34%
Louisiana	$1,754,897,350	$4,991,458,438	35%
Massachusetts	$2,331,035,783	$8,991,487,325	26%
Maryland	$1,915,963,513	$5,578,313,576	34%
Maine	$379,127,165	$1,355,222,292	28%
Michigan	$2,246,137,543	$9,230,535,302	24%
Minnesota	$1,694,806,934	$6,646,070,589	26%
Missouri	$1,455,806,531	$5,224,997,915	28%
Mississippi	$989,171,796	$3,123,699,935	32%
Montana	$183,909,719	$654,550,971	28%
North Carolina	$2,885,221,503	$8,925,213,476	32%
North Dakota	$107,761,974	$550,868,067	20%
Nebraska	$348,707,844	$1,536,397,490	23%
New Hampshire	$188,438,315	$935,283,430	20%
New Jersey	$2,026,553,145	$7,713,180,708	26%
New Mexico	$772,575,492	$3,058,468,905	25%
Nevada	$392,878,828	$1,130,300,678	35%
New York	$11,705,399,770	$43,041,399,327	27%
Ohio	$3,635,237,773	$12,061,645,064	30%
Oklahoma	$881,798,549	$3,349,528,009	26%
Oregon	$694,067,782	$2,459,665,555	28%
Pennsylvania	$4,388,311,450	$12,500,716,474	35%
Rhode Island	$459,724,049	$1,647,539,588	28%
South Carolina	$1,029,365,616	$4,347,468,122	24%
South Dakota	$162,318,249	$673,099,924	24%
Tennessee	$1,896,201,440	$6,361,769,298	30%
Texas	$4,854,303,254	$16,657,264,280	29%
Utah	$379,331,640	$1,643,199,371	23%
Virginia	$1,439,820,310	$4,660,591,700	31%
Vermont	$197,752,835	$882,793,847	22%
Washington	$1,584,641,237	$5,834,091,924	27%
Wisconsin	$999,308,579	$4,588,779,845	22%
West Virginia	$770,601,990	$2,401,910,136	32%
Wyoming	$120,862,956	$503,165,808	24%
USA Total	**$83,932,978,385**	**$296,829,612,488**	**28%**

Source: Special Needs Consulting Services tabulations using CMS MSIS data.

II. States' Involvement In Medicaid Capitation Contracting

The ten states that most extensively used capitation contracting for disabled beneficiaries are shown in Exhibit 3. These ten states represent 23% of nationwide Medicaid spending for the non-dual disabled adults, but accounted for 62% of all capitation expenditures in this subgroup. Arizona uses the capitation contracting model to arguably the greatest possible extent (due to retrospective eligibility and other Medicaid coverage dynamics, it is not likely possible to "capitate" 100% of Medicaid spending). The fact that Arizona has reached this level serves as a benchmark in terms of the "room" that exists between every other state's level of reliance on integrated care for this subgroup and maximum use of capitation contracting.

Exhibit 3. States With Largest Proportion of Capitation Contracting for Disabled Non-Duals, 2008

State	Total Expenditures, Disabled Non-Duals	Capitation Spending, Disabled Non-Duals	Percent Paid Via Capitation
Arizona	$1,516,554,548	$1,254,809,507	83%
Pennsylvania	$4,388,311,450	$3,138,611,001	72%
New Mexico	$772,575,492	$447,113,839	58%
Michigan	$2,246,137,543	$1,295,048,653	58%
Oregon	$694,067,782	$329,441,126	47%
Maryland	$1,915,963,513	$706,486,701	37%
Delaware	$271,451,712	$94,536,037	35%
Ohio	$3,635,237,773	$1,159,526,827	32%
Virginia	$1,439,820,310	$453,157,891	31%
Massachusetts	$2,331,035,783	$602,980,322	26%

Source: Special Needs Consulting Services tabulations using CMS MSIS data.

At the opposite end of the spectrum, 17 states did not engage in capitation contracting for their non-dual eligible disabled population during 2008 (or did so with less than 1% of their expenditures). These states are Alaska, Arkansas, Connecticut, Georgia, Idaho, Illinois, Louisiana, Maine, Mississippi, Montana, Nevada, New Hampshire, North Dakota, South Dakota, Vermont, West Virginia and Wyoming. Another seven states capitated less than 5% of their disabled non-dual Medicaid expenditures during 2008: Hawaii, Iowa, Minnesota, Missouri, North Carolina, Oklahoma and Washington. Among the above group of 24 states, several already use capitation extensively for their TANF populations, including Connecticut, Georgia, Hawaii, Minnesota, Missouri, Nevada, Washington and West Virginia.[2]

[2] Connecticut is discontinuing capitation contracting with at-risk MCOs and switching to an administrative services only integrated care program that will include both TANF and disabled beneficiaries. Hawaii has expanded its statewide capitation program to include disabled beneficiaries.

A detailed portrayal of the degree to which each state has utilized capitation contracting for various Medicaid beneficiary subgroups is tabulated in Exhibit 4.

Exhibit 4. Use of Capitation Contracting, 2008

	Percentage of Medicaid Expenditures Paid Through Capitation						
State	All Beneficiaries	Dual Eligibles	All Non-Duals	TANF and Other Non-Disabled (Non-Duals)	Disabled Non-Duals	Disabled Children (Non-Duals)	Disabled Adults (Non-Duals)
Alaska	0%	0%	0%	0%	0%	0%	0%
Alabama	16%	9%	22%	30%	11%	13%	10%
Arkansas	0%	0%	0%	0%	0%	0%	0%
Arizona	83%	89%	81%	81%	83%	94%	74%
California	21%	16%	24%	37%	10%	15%	8%
Colorado	17%	19%	16%	19%	13%	11%	13%
Connecticut	5%	0%	13%	27%	0%	1%	0%
District of Columbia	18%	-1%	30%	52%	13%	60%	1%
Delaware	38%	1%	53%	62%	35%	43%	30%
Florida	19%	6%	30%	34%	25%	17%	28%
Georgia	32%	1%	44%	70%	1%	2%	1%
Hawaii	36%	0%	54%	82%	3%	1%	3%
Iowa	5%	2%	7%	9%	5%	4%	5%
Idaho	2%	2%	2%	5%	0%	0%	0%
Illinois	2%	0%	3%	6%	0%	0%	0%
Indiana	24%	0%	39%	66%	6%	18%	3%
Kansas	23%	6%	34%	53%	11%	25%	6%
Kentucky	17%	4%	22%	26%	19%	29%	15%
Louisiana	0%	0%	0%	0%	0%	0%	0%
Massachusetts	27%	9%	40%	52%	26%	34%	24%
Maryland	34%	2%	49%	62%	37%	33%	38%
Maine	0%	0%	0%	0%	0%	0%	0%
Michigan	51%	39%	62%	65%	58%	48%	61%
Minnesota	32%	20%	41%	72%	4%	1%	5%
Missouri	21%	1%	31%	54%	1%	1%	1%
Mississippi	0%	0%	0%	0%	0%	0%	0%
Montana	0%	0%	0%	0%	0%	0%	0%
North Carolina	1%	1%	1%	1%	2%	3%	1%
North Dakota	0%	0%	0%	0%	0%	0%	0%
Nebraska	6%	0%	9%	11%	6%	4%	6%
New Hampshire	0%	0%	0%	0%	0%	0%	0%
New Jersey	23%	2%	42%	66%	17%	29%	14%
New Mexico	50%	2%	72%	81%	58%	69%	55%
Nevada	14%	0%	19%	37%	0%	1%	0%
New York	18%	5%	29%	46%	11%	8%	12%
Ohio	33%	1%	51%	68%	32%	3%	38%
Oklahoma	4%	1%	5%	7%	2%	3%	2%
Oregon	45%	17%	59%	66%	47%	51%	46%
Pennsylvania	53%	9%	76%	82%	72%	79%	67%
Rhode Island	22%	0%	38%	65%	9%	27%	1%
South Carolina	9%	4%	13%	16%	9%	15%	7%
South Dakota	1%	0%	2%	2%	0%	0%	0%
Tennessee	29%	18%	35%	43%	24%	14%	28%
Texas	21%	9%	26%	37%	10%	4%	14%
Utah	11%	17%	5%	4%	7%	9%	6%
Virginia	27%	1%	41%	49%	31%	27%	33%
Vermont	0%	0%	0%	0%	0%	0%	0%
Washington	21%	1%	35%	63%	2%	0%	2%
Wisconsin	29%	17%	42%	61%	21%	6%	26%
West Virginia	11%	4%	16%	38%	0%	0%	0%
Wyoming	0%	0%	0%	0%	0%	0%	0%
USA Total, Percent Capitated	23.0%	8.5%	32.1%	44%	18%	20.5%	17%

Source: Special Needs Consulting Services tabulations using CMS MSIS data.

It is common for states to rely extensively on the capitated model for their TANF population, but to *not* do so for their disabled non-dual beneficiaries. Table 5 presents the 21 states that have at least a 25 percentage point differential in the degree to which capitation contracting is used for their TANF populations above and beyond that used for their disabled non-dual subgroup. Nationwide, there is a 26 percentage point differential between TANF (where 44% of spending is capitated) and disabled non-duals (where 18% of spending is capitated).

Table 5. States with Widest Differential in Use of Capitation Between TANF and Disabled Beneficiaries, 2008

State	Percent Capitated, TANF & TANF-Related	Percent Capitated, Disabled Non-Duals	Differential
Hawaii	82%	3%	80%
Georgia	70%	1%	69%
Minnesota	72%	4%	68%
Washington	63%	2%	61%
Indiana	66%	6%	60%
Rhode Island	65%	9%	56%
Missouri	54%	1%	53%
New Jersey	66%	17%	48%
Kansas	53%	11%	42%
Wisconsin	61%	21%	41%
District of Columbia	52%	13%	39%
West Virginia	38%	0%	38%
Ohio	68%	32%	36%
Nevada	37%	0%	36%
New York	46%	11%	35%
California	37%	10%	27%
Connecticut	27%	0%	27%
Delaware	62%	35%	27%
Texas	37%	10%	27%
Massachusetts	52%	26%	27%
Maryland	62%	37%	25%

Source: Special Needs Consulting Services tabulations using CMS MSIS data.

Several states have utilized the capitation model extensively for a certain disabled age cohort – but not others. Exhibit 6 presents the ten states with the largest differential between the use of capitation for disabled adults and disabled children.

Table 6. Ten States with Widest Differential in Use of Capitation Between Non-Dual SSI Adults and SSI Children, 2008

State	Percent Capitated, Disabled Adults	Percent Capitated, Disabled Children	Differential
District of Columbia	1%	60%	59%
Ohio	38%	3%	35%
Rhode Island	1%	27%	26%
Wisconsin	26%	6%	21%
Arizona	74%	94%	20%
Kansas	6%	25%	19%
New Jersey	14%	29%	15%
Indiana	3%	18%	14%
New Mexico	55%	69%	14%
Kentucky	15%	29%	14%

Source: Special Needs Consulting Services tabulations using CMS MSIS data.

III. Summary Findings and Policy Implications

This paper has quantified the significant opportunity that exists in several states broaden the use of the MCO contracting model to their disabled beneficiaries. Nationwide, less than 20% of expenditures for disabled non-dual eligibles occurred through capitation payments to integrated care organizations. This population's characteristics are highly conducive to positive impacts (both clinical and financial) from well-designed and effectively implemented integrated care initiative. States continue to face an unprecedented fiscal crisis and are encouraged to closely explore their opportunities to expand the use of coordinated care for this subgroup. Every state except Arizona has a substantial opportunity to broaden the use of integrated care for disabled beneficiaries.

While many policymakers view the high-need disabled subgroup as being where integrated care programs can do the most good, many others are wary that this is also where managed care can cause the most harm. However, as more experience and sophistication accumulates in the Medicaid coordinated care arena with high-need beneficiaries, there is a growing appreciation that well-designed and well-implemented initiatives will improve health status as well as reduce costs relative to a fee-for-service setting where the government is essentially paying for "whatever happens to happen." Nonetheless, it is clearly incumbent upon states that utilize the MCO contracting model to carefully tailor the program requirements, select high-quality MCOs, and monitor their programs closely and effectively.

Importantly, several states that have included their disabled populations on a large scale have found these programs to be highly successful clinically and financially. With the existing levels of knowledge and experience in this arena, it is clearly possible to design and operate these programs effectively. Several states have recently expanded the use of capitation contracting for disabled beneficiaries (e.g., Hawaii, Rhode Island and Tennessee) and others are currently in the process of doing so (e.g., Kentucky and Texas). All of these states have taken advantage of the lessons learned to date around the country in designing their integrated care program expansions. Some examples of specific techniques that are proving to work effectively include:

- The Medicaid agency continually providing one to two years of prior fee-for-service claims history to an MCO for each of its new enrollees, so that the health plan has knowledge of what services the individual has received, what diagnoses and conditions exist, what medications are being used, what providers are being utilized, etc. (without having to wait for several months for their own claims data to accumulate for these persons).

- MCOs conducting a detailed assessment of each new SSI enrollee and developing a care coordination plan that is shared with the member's primary care provider and with the member and/or the member's caregiver(s). This care coordination plan delineates action steps regarding medical treatment, outreach, and linkages to community support services.

- Ongoing updating and modification of the care coordination plan.

- Phasing in new SSI enrollment across a reasonably wide time span so that the MCOs can handle the volume of activities needed to effectively assess and educate new special needs members.

- Permitting enrollees to continue ongoing treatments with existing providers for at least the first six months of enrollment, whether these providers are in the MCO's network or not. This is particularly important for behavioral health services.

- The Medicaid agency establishing regulations that providers will not receive more than the Medicaid fee-for-service payment rate when out-of-network care occurs, to prevent providers from "holding MCOs hostage" for higher payments and to eliminate the haggling that must otherwise occur to determine reimbursement for out-of-network care.

- Extensive oversight of health plan performance, but within a collaborative environment where the state staff, the participating MCOs and many other stakeholders seek to learn from and work with one another to achieve the best long-term programmatic outcomes attainable.

Integrated care programs for high-need Medicaid beneficiaries can profoundly impact how health care is accessed, delivered and paid for. As such, many stakeholders are involved and the political outcomes of any given state's program design efforts have an element of unpredictability.

However, a strong programmatic case can be made that Medicaid has the least amount of coordinated care where such models are most needed. The traditional fee-for-service structure is not capable of achieving cost-effective outcomes and does little to ensure access or promote quality. States are encouraged to pursue opportunities to broaden their use of integrated care for their disabled beneficiaries.

APPENDIX A: STATES' 2008 SPENDING ON DISABLED NON-DUALS: TOTAL AND PMPM COSTS FOR CHILDREN AND ADULTS

	TOTAL COSTS			PMPM COSTS			AVERAGE NUMBER OF PERSONS COVERED			PERCENT OF COSTS PAID VIA CAPITATION		
STATE	Child (Under Age 21)	Adults	All Disabled Non-Duals	Child (Under Age 21)	Adults	All Disabled Non-Duals	Child (Under Age 21)	Adults	All Disabled Non-Duals	Child (Under Age 21)	Adults	All Disabled Non-Duals
Alaska	73,817,120	184,229,837	$258,046,957	$2,918	$2,609	$2,691	2,108	5,883	7,991	0%	0%	0%
Alabama	$264,463,877	$649,636,904	$914,100,781	$597	$803	$730	36,935	67,379	104,314	13%	10%	11%
Arkansas	$425,416,957	$516,165,524	$941,582,481	$1,194	$1,103	$1,142	29,690	39,015	68,705	0%	0%	0%
Arizona	$650,774,888	$865,779,660	$1,516,554,548	$1,788	$1,566	$1,654	30,334	46,072	76,406	94%	74%	83%
California	$2,260,106,122	$7,584,253,492	$9,844,359,614	$1,262	$1,402	$1,367	149,225	450,774	599,999	15%	8%	10%
Colorado	$223,128,956	$605,671,556	$828,800,512	$1,375	$1,684	$1,588	13,519	29,977	43,496	11%	13%	13%
Connecticut	$12,479,975	$733,526,935	$746,006,910	$1,259	$2,377	$2,342	826	25,715	26,541	1%	0%	0%
District of Columbia	$117,233,808	$466,713,495	$583,947,303	$1,607	$2,352	$2,152	6,081	16,533	22,613	60%	1%	13%
Delaware	$106,094,588	$165,357,124	$271,451,712	$1,671	$2,182	$1,949	5,291	6,316	11,607	43%	30%	35%
Florida	$1,145,941,860	$2,407,649,896	$3,553,591,756	$942	$1,312	$1,164	101,332	152,981	254,313	17%	28%	25%
Georgia	$452,968,432	$1,421,272,968	$1,874,241,400	$770	$1,327	$1,130	49,006	89,272	138,277	2%	1%	1%
Hawaii	$55,932,118	$183,883,996	$239,816,114	$1,787	$1,331	$1,415	2,608	11,512	14,120	1%	3%	3%
Iowa	$259,959,917	$466,539,322	$726,499,239	$1,753	$1,926	$1,860	12,361	20,188	32,549	4%	5%	5%
Idaho	$167,519,426	$286,805,113	$454,324,539	$1,632	$2,141	$1,920	8,553	11,163	19,716	0%	0%	0%
Illinois	$250,468,678	$2,563,841,765	$2,814,310,443	$832	$1,608	$1,485	25,091	132,851	157,942	0%	0%	0%
Indiana	$233,747,917	$1,085,062,619	$1,318,810,536	$1,219	$1,629	$1,537	15,983	55,521	71,504	18%	3%	6%
Kansas	$184,230,955	$459,459,555	$643,690,510	$1,313	$1,817	$1,637	11,689	21,072	32,761	25%	6%	11%
Kentucky	$420,398,482	$1,110,403,634	$1,530,802,116	$941	$1,040	$1,011	37,224	88,991	126,215	29%	15%	19%
Louisiana	$399,558,493	$1,355,338,857	$1,754,897,350	$803	$1,484	$1,244	41,453	76,122	117,575	0%	0%	0%
Massachusetts	$479,678,363	$1,851,357,420	$2,331,035,783	$874	$565	$610	45,726	272,878	318,604	34%	24%	26%
Maryland	$418,593,045	$1,497,370,468	$1,915,963,513	$1,635	$2,162	$2,020	21,338	57,720	79,058	33%	38%	37%
Maine	$129,279,308	$249,847,857	$379,127,165	$1,598	$1,115	$1,243	6,743	18,677	25,419	0%	0%	0%
Michigan	$593,833,187	$1,652,304,356	$2,246,137,543	$1,027	$1,153	$1,117	48,176	119,431	167,608	48%	61%	58%
Minnesota	$547,207,981	$1,147,598,953	$1,694,806,934	$2,342	$2,779	$2,621	19,472	34,407	53,879	1%	5%	4%
Missouri	$132,210,690	$1,323,595,841	$1,455,806,531	$1,230	$1,403	$1,385	8,954	78,624	87,578	1%	1%	1%
Mississippi	$297,023,118	$692,148,678	$989,171,796	$815	$1,041	$961	30,355	55,421	85,777	0%	0%	0%
Montana	$57,103,015	$126,806,704	$183,909,719	$1,626	$1,432	$1,487	2,927	7,379	10,305	0%	0%	0%
North Carolina	$965,011,870	$1,920,209,633	$2,885,221,503	$1,543	$1,685	$1,634	52,114	94,994	147,108	3%	1%	2%
North Dakota	$24,154,990	$83,606,984	$107,761,974	$1,832	$2,339	$2,203	1,099	2,979	4,077	0%	0%	0%
Nebraska	$78,193,066	$270,514,778	$348,707,844	$1,598	$2,207	$2,033	4,077	10,214	14,290	4%	6%	6%
New Hampshire	$20,586,982	$167,851,333	$188,438,315	$2,582	$1,787	$1,849	664	7,828	8,492	0%	0%	0%
New Jersey	$439,380,178	$1,587,172,967	$2,026,553,145	$1,275	$2,124	$1,856	28,710	62,265	90,976	29%	14%	17%
New Mexico	$170,986,768	$601,588,724	$772,575,492	$1,323	$2,030	$1,815	10,771	24,693	35,464	69%	55%	58%
Nevada	$94,619,587	$298,259,241	$392,878,828	$1,151	$1,969	$1,681	6,853	12,623	19,475	1%	0%	0%
New York	$2,191,463,666	$9,513,936,104	$11,705,399,770	$1,543	$2,816	$2,439	118,345	281,594	399,939	8%	12%	11%
Ohio	$675,742,648	$2,959,495,125	$3,635,237,773	$979	$1,710	$1,502	57,543	144,212	201,755	3%	38%	32%
Oklahoma	$229,932,226	$651,866,323	$881,798,549	$1,192	$1,513	$1,414	16,078	35,904	51,982	3%	2%	2%
Oregon	$147,966,839	$546,100,943	$694,067,782	$1,246	$1,496	$1,434	9,896	30,427	40,323	51%	46%	47%
Pennsylvania	$1,591,283,095	$2,797,028,355	$4,388,311,450	$974	$1,198	$1,106	136,208	194,586	330,794	79%	67%	72%
Rhode Island	$149,545,179	$310,178,870	$459,724,049	$1,550	$1,711	$1,655	8,039	15,106	23,145	27%	1%	9%
South Carolina	$317,798,277	$711,567,339	$1,029,365,616	$922	$1,360	$1,186	28,725	43,607	72,333	15%	7%	9%
South Dakota	$54,634,282	$107,683,967	$162,318,249	$1,466	$1,849	$1,699	3,106	4,854	7,960	0%	0%	0%
Tennessee	$462,959,604	$1,433,241,836	$1,896,201,440	$874	$1,030	$987	44,146	115,985	160,131	14%	28%	24%
Texas	$1,764,484,661	$3,089,818,593	$4,854,303,254	$1,140	$1,301	$1,237	128,999	197,937	326,936	4%	14%	10%
Utah	$102,168,139	$277,163,501	$379,331,640	$1,686	$1,842	$1,797	5,050	12,537	17,587	9%	6%	7%
Virginia	$319,114,931	$1,120,705,379	$1,439,820,310	$1,047	$1,673	$1,477	25,404	55,834	81,238	27%	33%	31%
Vermont	$82,666,192	$115,086,643	$197,752,835	$2,285	$1,544	$1,786	3,015	6,213	9,228	0%	0%	0%
Washington	$344,706,579	$1,239,934,658	$1,584,641,237	$1,283	$1,359	$1,341	22,397	76,058	98,454	0%	2%	2%
Wisconsin	$273,295,544	$726,013,035	$999,308,579	$767	$1,360	$1,123	29,693	44,483	74,176	6%	26%	21%
West Virginia	$140,353,453	$630,248,537	$770,601,990	$961	$994	$988	12,172	52,830	65,002	0%	0%	0%
Wyoming	$32,969,336	$87,893,620	$120,862,956	$1,745	$2,320	$2,129	1,574	3,157	4,731	0%	0%	0%
USA Total	**$21,033,189,368**	**$62,899,789,017**	**$83,932,978,385**	**$1,155**	**$1,488**	**$1,388**	**1,517,672**	**3,522,792**	**5,040,463**	**20%**	**17%**	**18%**

Source: Special Needs Consulting Services tabulations using CMS MSIS data.